Summary of Literature on Impact of Administrative and Regulatory Costs and Mandates
OIC Policy Division
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Introduction

The Washington State Office of the Insurance Commissioner (OIC), Policy Division, reviewed literature addressing the impact of administrative and regulatory costs and mandates. The OIC conducted the research of literature using the Internet and all of the materials reviewed are accessible on-line. The summary of literature set forth below is representative of the information available on the issues, but it is not intended to be an exhaustive review of the subjects.

The review of available literature revealed that there is minimal detailed information on the impact of administrative and regulatory costs and mandates in Washington State. General trend data and information relating to administrative impact and mandates in other states and on a national level was more readily available.

Analysis of the literature reveals that both administrative and regulatory requirements and mandates have some impact on the cost of providing private health insurance. However, the literature does not reveal any conclusive information about the cost of specific administrative requirements or mandates in Washington State. In addition, because of the limited Washington-State-specific information, and the often-significant variations in the data, methodology and analysis underlying the findings, many of the generalized findings are inconsistent. As the task force members review the detailed studies from other states, they will notice a wide range of costs attributed to a variety of different mandates.

Administrative Costs (Washington State)

- The OIC prepared an analysis of expenses for Health Carriers in Washington State, based on information obtained from the 2002 Annual Statement pages filed with the OIC. The analysis revealed that administrative expenses were 12.56% of overall revenues. [See Exhibit 1]. Further analysis of the specific components of administration cost determined that salaries, wages and other benefits was the largest component of administrative cost, at 46.83% of the total administrative expenses. Rent was the second largest component, at 10.76% of the total administrative costs. [See Exhibit 2].

  "2002 Analysis of Operations by Line of Business – 007: State Summary" and "2002 Exhibit Analysis of Expenses – 014: Summary of Health Carriers in Washington State" prepared by the Washington State Office of the Insurance Commissioner, based on data from the National Association of Insurance Commissioners (NAIC), August 2003.

❖ In 1993, the percent of premiums used for administration of insurance plans in Washington State was 9.8%. By 1997, the percent of premiums used for administration rose to 15%. The increase in administrative costs could be the result of a number of factors, including new investments in information systems, costs of plan acquisitions or consolidations and higher salaries.

Based on data from the OIC, the following chart depicts the percent of premiums expended on administration from 1986 to 1997:

Insurance Spending and Finance	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Percent of Premiums to Administration	10.2%	9.4%	9.9%	8.9%	10.0%	10.1%	9.9%	9.8%	11.7%	12.8%	14.1%	15.0%

However, not all plans report administrative costs in the same manner. Some plans report certain expenditures as direct care costs, while others report the same expenditures as administration.

> "1999 Pulse Brief: Tracking Washington's Health System," Vital Signs of Washington's Health, 1999. [Tab 1] [1]

Administrative and Regulatory Costs (Generally)

❖ "There is very limited empirical literature demonstrating the relationship between small-group reforms and premiums. Early studies showed that rate restrictions and guaranteed issue of policies have raised the cost of insurance policies (IHPS, 1955; AAA, 1993). Another study found some evidence that extensive small-group reforms (e.g., guaranteed issue and renewal, rating reforms, and pre-existing condition constraints) may have been associated with premium increases of between 4 and 6 percent in small firms (Simon, 1999). However, a more recent study comparing states that had adopted small-group market reforms with those that had not, found no effect on premiums, variability in premiums, or the rate of change in premiums (Marquis and Long, 2001)."

> Washington State Planning Grant Consultant Team, "Market and Regulatory Reforms to Expand Health Insurance Coverage," p. 8, funded by the U.S. Department of Health and Human Services, Health Resources Administration, Grant #1 P09 OA00002-01, April 2002. [Tab 2]

[1] Tab numbers refer to the location of the source document in the reference notebook compiled by the Office of the Insurance Commissioner. Notebooks containing reference material cited in this document will be provided to Task Force members and a copy of the notebook will be available for public review at the Office of the Insurance Commissioner.

❖ Since 1998, heath administration costs per member per month have increased by 6.2% on average, while premium rates have increased 8.4% on average.

- "Account Membership and administration was the area with the fastest growth, increasing at an 8.2% average annual rate. Areas include[d] in this category are Enrollment / Membership / Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information System Expenditures. . . . In aggregate, these costs totaled $9.02 per member per month."

- "Marketing and Actuarial expenses grew at 6.4%, on average. These expenses include Product Development / Market Research, Rating and Underwriting, Sales and Marketing, Commissions and Advertising and Promotion. . . . This category was responsible for costs of $5.36 [per member per month] in 2001."

- "Corporate Services was an area of relatively modest growth, at 4.3%, on average. This expense classification consists of Finance and Accounting, Actuarial, Corporate Services (Including HR, Facilities, Legal, [and] Regulatory), Corporate / Executive as well as Association Dues and Miscellaneous Business Taxes. . . . These expenses comprised $5.07 of the total administrative costs in 2001."

- "Medical and Provider Management was the slowest growing area of administrative expense. This are consists of Provider Network Management and Services and Medical Management / Quality Assurance / Wellness / Grievance & Appeals. This expense area grew by only 2.9% on average over that period. Representing $1.50 of the total $2.40 of this category, Medical Management remained substantially unchanged during this period."

  Plan Management Navigator, p. 2, Sherlock Company, February 2003. [Tab 3]

❖ In its analysis of private health insurance costs per person covered, based on data gathered by CMS, the Kaiser Family Foundation concluded that the cost per enrollee for expenses not related to direct care services (such as administrative costs and profits) continued to rise, from $85 in 1986 to $270 in 2000. The most rapid growth occurred in the four-year period from 1987 to 1990, when these costs rose 125%. From 1997 to 2000, the cost per enrollee rose 30%.

"Trends and Indicators in the Changing Health Care Marketplace," Exhibit 6.10, Chartbook, Kaiser Family Foundation, May 2002. [Tab 4]

❖ Trend factors driving rising costs in healthcare premiums from 2001 to 2002 include government mandates and regulation (over 1,500 existing mandates at the state and federal level, new mandated benefits, elimination or limitation of cost-control tools and regulatory requirements). This trend factor amounts to 2.0 percentage points, which is 15% of the total increase.

The spread of mandates and increasing regulations in the healthcare system appear adding to the costs associated with government regulation. The contribution of mandates and government regulation to the cost of health care premiums is estimated to be about 15 percent of the overall increase, which represents $10 billion of the overall increase in health premiums.

"The Factors Fueling Rising Healthcare Costs," PriceWaterhouseCoopers, April 2002. [Tab 5]

❖ "Data [from the Centers for Medicare and Medicaid Services (CMS)] for 2000 indicate that the net cost of administration represented 12 percent of all insurance spending. The administrative costs incurred by insurers represent approximately 6 percent of total personal health expenditures. These costs are, in aggregate, lower than administrative costs incurred by hospitals or by physicians."

"Managed care techniques complicate the analysis of administrative costs. In general, utilization review, antifraud activities, and other cost management programs represent new administrative expenses that reduce overall spending. For instance, HIAA data show that health insurers' antifraud activities in 1998 saved more than $11 for every dollar spent. As a result of these important and cost-effective activities, the percent of premiums attributed to administrative expenses tends to rise."

"In addition, the way a network-based health plan contracts with providers may affect the accounting for administrative expenses. Amounts paid to providers or provider groups, in general, are treated as benefit costs. In a managed care environment, provider groups may be responsible for administrative functions that would otherwise be performed by the health plan administrator. If the reimbursement for those services is included in the overall capitation, then it will be treated on the insurer's books as a benefit cost rather than an administrative cost. This makes comparisons of administrative cost levels between different types of health benefit programs very difficult."

"Why Do Health Premiums Rise," p. 17, Issue Brief, HIAA, September 2002, Health Insurance Association of America. [Tab 6]

❖ Administrative costs for the public and private sectors are not directly comparable. Private sector administrative costs include "non-administrative" costs, such as premium taxes and reserve requirements. From 1996 to 2001, public administrative costs grew at a faster rate than private costs. The cost of administration and the net cost of private health insurance are modest compared to other health care costs, including prescription drugs, physician and clinical services and hospital care.

Douglas Sherlock, "Hospital versus Administrative Cost Increases, 1996 – 2001," Charts 3 and 6, AAHP Testimony: Comments regarding Hearings on Health Care and Competition Law and Policy, February 25, 2003. [Tab 7]

❖ Administrative expenses (including program administration and net cost of private health insurance) increased 11.2 percent in 2001. In 2002, the United States spent $112 billion on administrative expenses, and those costs are projected to rise to $223 billion by 2012.

Administrative costs for private insurers include marketing, sales commissions, profits and reserves, enrollment and claims payment. In contrast, government programs do not incur expenses for marketing and sales and do not require premiums high enough to generate profits and reserves.

Private insurance administrative costs are 11.9 percent of private insurance expenditures. The administrative costs for government programs (including Medicare, Medicaid, Veterans Administration, Department of Defense, Indian Health Service, and other direct health services delivery programs) average 4.6 percent of public health expenditures.

> Karen Davis, President, and Barbara Cooper, Senior Program Officer, The Commonwealth Fund, "American Health Care: Why So Costly?" Testimony before the Senate Appropriations Committee, Hearing on Health Care Access and Affordability: Cost Containment Strategies, June 11, 2003. [Tab 8]

❖ "One of the most direct and quantifiable [regulatory] costs that insured health plans incur compared with self-funded plans results from state premium taxes and other assessments paid by health insurers. Most of the costs associated with taxes result from premium taxes that increase costs to insured health plans by about 2 percent in most states." [p. 6]. Health insurers also may be responsible for paying other miscellaneous assessments collected by the states, including assessments for guaranty funds and high-risk pools.

"The cost impact of mandated benefits varies because states differ in the number and type of mandated benefits. The available studies reflect this cost variation, estimating higher claims costs in states with the most mandated benefits and more costly benefits, such as treatment for mental health and substance abuse. However, the studies are limited because their measurement of costs does not account for certain other cost elements, including administrative costs for multi-state employers and a loss of flexibility claimed by employers in designing cost-effective benefit packages." [p. 8].

"State solvency requirements add costs only to the extent that they exceed prudent industry practices a health insurance carrier would follow in the absence of state requirements." [p. 17]. Additionally, a state's oversight of health insurers' solvency may also add administrative costs for the insurers who must comply with reporting and review requirements.

> "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance," GAO Report to the Honorable James M. Jeffords, U.S. Senate, GAO/HEHS-96-161, August 1996. [Tab 9]

Impact of Various Mandates

❖ Cost Effects of State-Mandated Benefits on Health Insurance Premiums:

- The absolute number of mandates does not matter much. While some mandates raise premiums, others actually save costs (Henderson, Seward & Taylor, Baylor University, 2003 forthcoming).

  PowerPoint presentation of Tom Miller, Cato Institute, before the FTC/DOJ Health Care Hearings on Mandated Benefits, June 25, 2003. [Tab 10]

❖ Under Maryland's insurance law, there are 40 "required health insurance benefits for services" that must be included in health plans. Financial analysis indicates that the total cost of inclusion of all these mandates in health policies is about 15%. The analysis is specific to group and individual insurance plans, the Comprehensive Standard Health Benefit Plan for small groups and the Maryland State Employee Benefit Plan.

Maryland has a statutory affordability cap for the cost of mandated benefits. That cap is 2.2% of the average annual wage in Maryland. The cost of current mandates as a percentage of average wage has increased slightly since 2001 and is presently running just under the affordability cap. The increased cost is the result of new legislation expanding mandates and the increase in the cost of health care faster than the average wage.

Maryland Health Care Commission, *Mandated Health Insurance Services Evaluation,* December 31, 2002. [Tab 11]

❖ While the cost of each individual mandate may be relatively low, the aggregate cost of all mandates may serve to drive people out of the health insurance market.

The State of Virginia, with 53 mandates, is an example of the cumulative impact of mandated benefits. It is estimated that those mandates have increased the cost of a health policy by 21%.

CAHI Policy Brief, *Mandated Health Insurance Benefits*, Volume 5, Number 1, January 2002. [Tab 12]

❖ Primary findings from the July 2001 Issue Brief by the Minnesota Department of Health – Health Economics Program:

- "Mandated health benefits raise premium costs to some degree; however these increases are generally more modest than commonly cited figures;
- The type of mandate appears to have a much greater impact on cost than the sheer number of mandates enacted;

- Benefit packages offered through self-funded or fully-insured plans are generally quite similar to one another and the evidence suggests that most self-funded plans cover the majority of mandated benefits; and
- Mandates do not appear to play a major role in a firm's decision to self-insure."

"*Mandated Health Insurance Benefits and Health Care Costs*," p.1, Issue Brief, Minnesota Department of Health, Health Economics Program, July 2001. [Tab 13]

❖ Findings from the September 2000 Cost Impact Study of Mandated Benefits in Texas:

- The mandated benefits studied represent 6.3% to 7.6% of the current group insurance costs.
- Mandates do not greatly influence the affordability and availability of health insurance.
- The added incremental cost of each mandate may drive a marginal number of employers to choose not to offer health insurance coverage.
- The result of treatment received in connection with the mandates studied was expected to improve and maintain the health of residents.
- Many of the mandates remove the potential of a large financial burden for individuals.
- Although a number of mandates do not significantly contribute to the health and welfare of individuals, they allow more choice in healthcare options.

Susan Albee et al., *Cost Impact Study of Mandated Benefits in Texas - Report # 2*, September 28, 2000. [Tab 14]

❖ Based upon a nationwide cross-section of employers in 1989, Acs et al. (1992) determined that premiums increased by 4 to 13 percent as a direct result of state mandated benefits.

The increasing cost of coverage due to mandates may result in employers or individuals deciding not to purchase health insurance coverage. However, the most frequently mandated benefits did not significantly impact the likelihood that an employer would self-insure.

Gail Jensen and Michael Morrisey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance* (Washington, D.C.: Health Insurance Association of America, January 1999). [Tab 15]

❖ The cost of health care and health premiums increase as the result of government regulation at both the state and federal level. Examples include mandates to cover specific benefits or minimum hospital stays, regulations requiring appeals procedures and restrictions on a carrier's ability to reduce or deny benefits for pre-existing conditions.

Employers respond to the increasing cost of mandates by reducing or eliminating benefits, raising cost-sharing requirements or eliminating coverage completely.

Although proposals that would impose new mandates on health plans are meant to improve the value of insurance to consumers, they could also raise insurance costs and increase the numbers of uninsured.

> Testimony of Dan Crippen, Director, Congressional Buget Office, before the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, on Health Care Costs and Insurance Coverage, June 11, 1999. [Tab 16]

- As federal and state regulators pass new mandates, the impact may increase costs by a percentage point or two. Some mandates have a greater impact. The overall cumulative impact of added regulation is that more and more people will be forced to go without insurance.

  Professors at Wayne State University and the University of Alabama – Birmingham determined that as many as one in four Americans lack health insurance because of benefit mandates. Each additional mandate significantly lowers the probability that a firm or an individual will have health insurance.

  > Grace-Marie Arnett, "Rising Costs, Reduced Access: How Regulation Harms Health Consumers and the Uninsured," *The Heritage Foundation Backgrounder # 1307* (Washington D.C.: The Heritage Foundation, June 20, 1999). [Tab 17]

- An analysis prepared for the National Center for Policy Analysis by Milliman & Robertson estimates the costs of 12 of the most common mandates and concludes that, together, they can increase the cost of insurance by as much as 30%.

  When employers who canceled their employees' health insurance policies were polled on why they did so, the majority stated that it was because of the high price. Therefore, while the existence of mandated benefits means that people with health insurance have more health care options, it also means that fewer people are insured.

  > "The Cost of Health Insurance Mandates," Brief Analysis, No. 237, National Center for Policy Analysis, August 13, 1997. [Tab 18]

Recommendation

Members of the task force should collaborate and focus on further research aimed at framing a more detailed cost analysis of the impact of mandated benefits specific to Washington State. Such analysis should include mandates for health benefits (services), administrative mandates and access mandates.